DWS-HCD 874
Rev. 10/2015

State of Utah
Department of Workforce Services

H.E.A.T. PROGRAM/ HELP/EAF APPLICATION (HOME ENERGY ASSISTANCE TARGET)

1. Applicant Information:

Name: _____ Date: _____
First Middle Last

Social Security #: _____ Gender: ☐ Male ☐ Female Birth Date: _____
Month Day Year

Street Address: Mailing Address: (if different)

_____ _____
Apartment Complex Name

_____ _____
Street Address Unit # Street Address or PO Box

_____ _____
City State Zip City State Zip

Phone #: _____ Secondary Phone #: _____

Email Address: _____

2. Have you applied for HEAT assistance before? .. ☐ Yes ☐ No Date: _____ Office: _____

3. Ethnic background: ☐ Native American ☐ White ☐ Hispanic ☐ Black ☐ Asian
☐ Pacific Islander ☐ Other: _____

4. Are you a US Citizen? ..... ☐ Yes ☐ No
If no, provide documentation of legal residency.

5. Other persons in household including other adults and children: *(Continue list on back if needed.)*

Name (First, Last)	**Relation**	**Birth date** mm/dd/yyyy	**Age**	**Social Security Number**	**Sex**	**Income**	**Citizen**
					M F	Y N	Y N
					M F	Y N	Y N
					M F	Y N	Y N
					M F	Y N	Y N
					M F	Y N	Y N

6. Household Composition:

Child under age 3..... ☐ Yes ☐ No
Child age 3 through 5..... ☐ Yes ☐ No
Age 60 and older..... ☐ Yes ☐ No
Handicapped/disabled..... ☐ Yes ☐ No
U.S. Citizens (all?)..... ☐ Yes ☐ No
Receiving SNAP (Food Stamps)..... ☐ Yes ☐ No
U.S. Veteran..... ☐ Yes ☐ No

Number of Adults: _____ Number of Children (under 18): _____ Total # in Household: _____

7. Your dwelling is a (check one): ☐ House ☐ Apt. (3 or more units) ☐ Duplex ☐ Basement Apt.
☐ Mobile Home ☐ Small Trailer ☐ Boarding Room ☐ Condo ☐ Townhouse

8. Do you rent or own your home? _____ What is your primary heating source? _____
What is your secondary heating source? _____ What is your primary cooling source? _____

9. Is your rent subsidized? _____ How much is your monthly rent/mortgage payment? $ _____

10. Does your rent include utilities? ☐ Yes ☐ No Which utilities? _____

11. H.E.A.T. payment is to be issued to the following utility(ies) in the percentages listed below (100%, 50/50%, or 25/75%). The utility vendor and percentage cannot be changed after the application is submitted. Be sure to circle the account status for each utility. If you circle 48 HR you must include a copy of the 48 HR shut-off notice. For propane, circle **on** if you have fuel, **off** if you are out of fuel, and 48 HR if you will run out of fuel within 48 hours.

%	Name of Utility Vendor(s)	Account Status (circle one)	Utility Account Number(s)	Name on account (provide explanation if not applicant)
		ON / OFF / 48 HR		
		ON / OFF / 48 HR		

Name of electricity vendor and account number if not included above: _____

12. Income: Indicate which sources of income and/or assistance you and anyone living in your household receive. Attach all pay stubs and documentation of all other income for LAST MONTH. Any adults in the household with no income or net business profit must complete and include an Income Deficit Statement form.

Earned Income Type	Y / N	Name of Recipient	Date Paid	Gross Amount	How often is income received? (weekly, bi-weekly, twice monthly, monthly)
Employment	Y / N				
Employment	Y / N				
Employment	Y / N				
Employment	Y / N				
Self-Employment	Y / N				
Self-Employment	Y / N				

Unearned Income Type	Y / N	Name of Recipient	Date Paid	Gross Amount	How often is income received? (weekly, bi-weekly, twice monthly, monthly)
Social Security, SSI, SSD	Y / N				
Social Security, SSI, SSD	Y / N				
Social Security, SSI, SSD	Y / N				
Unemployment	Y / N				
Unemployment	Y / N				
Alimony	Y / N				
Annuity	Y / N				
Child Support	Y / N				
General Assistance	Y / N				
Pension	Y / N				
Railroad Retirement	Y / N				
Rental Property	Y / N				
Retirement	Y / N				
TANF/FEP	Y / N				
Veterans Benefits	Y / N				
Workers Comp	Y / N				
OTHER	Y / N				

Attach additional sheet if needed to provide information from all income sources for all household members.

13. Medical Deductions: List any health, dental, or vision insurance premiums, payments for prescription medicines, oxygen, glasses/contacts, hearing aids, and payments to doctors, hospitals, or medical/dental clinics paid ***last month***. All receipts must be paid in the same month as the month of income listed in number 12. (Attach additional sheet if needed.)

Name of Person	Type of Medical Expense	Proof of Payment	Date Paid	Amount Paid
				$
				$
				$
				$

14. Alimony/Child Support Deductions: Did you or anyone in your household pay alimony or child support last month? ☐ Yes ☐ No

If yes, you must include copies of the receipts with this application. All receipts must be paid in the same month as the month of income listed in question 12.

DECLARATION: I understand that neither the vendor nor the percentage of my H.E.A.T. payment may be changed. By signing this application, I certify under penalty of perjury that the information I provided on this application is true, and that giving false information may require repayment of any funds received. I agree to cooperate with state and federal officials in any review of my application and to provide information necessary to verify any statement herein. I give permission for my utility companies to provide my billing and usage information to the state of Utah. I hereby authorize H.E.A.T. program officials to make inquiry of persons, companies, financial institutions, and other state and federal agencies to assist in the processing of my application. I understand that if I do not provide the necessary information to establish my eligibility within 10 days from this date that my application may be denied. I understand that I have the right to a Fair Hearing if my application is denied. I further understand that if Federal H.E.A.T. funds are exhausted prior to processing this application, the State of Utah is under no obligation to make payment. I understand that if my application is denied or if the local office has failed to act upon my application within 45 days, I have the right to request a Fair Hearing. I verify that, if eligible, I would like to receive the Rocky Mountain Power (RMP) HELP discount program and Questar Gas Energy Assistance Fund (EAF) credit.

Signature _____ **Date** _____

If you believe you have been treated unfairly by the HEAT program, call 866-205-4357 for assistance.

OFFICE USE ONLY

1. INCOME FORMULA

Total NET Income $_____

divided by 100% of the Poverty Amount for a household size of ____ (see table) $_____ = _____%

(Ineligible if over 150%)

Subtract the % amount from $205.00 = $_____

Total #1: $_____

2. ENERGY BURDEN

FUEL TYPE: _____

Household Energy Cost (Select one):

Actual Costs $_____

House Standard $_____

Apt. Stand. $_____

Room & Board Stand. _____ (10% of rent)

Divide Energy Cost selected above by total NET income _____ = _____ X $7.00 = _____

(Max. of 25)

Total #2: $_____

3. TARGET GROUPS

Child under 6 _____

Disabled _____

Over 60 _____

(If household has any members in a target group add $150)

Total #3: $_____

Add totals from boxes 1, 2, & 3 for estimated Total HEAT Benefit: $_____

Equal Opportunity Employer Program

Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.